Maine Birth Defects Program
Confidential Medical Report

Please Print Clearly using Blue or Black Ink (See Instructions on Reverse Side) **Today's Date:_____**

Child's Information

Name: _____ _____ _____ DOB: ____/____/____ or
Last First M.I.

Sex: M F Undesignated Birth Status: Live Still EDD: ___/___/_____

Birth Facility: _____ MR# _____

Transfer Facility: _____ MR# _____

Date of Discharge/Transfer: ____/____/____ If Deceased: Date of Death: ____/____/____ Autopsy: Yes No

Diagnosis:

☐ Prenatal ☐ At Birth ☐ Other_____

☐ Pending ☐ Confirmed
Diagnosis confirmed by: ☐ Ultrasound ☐ Cytogenetics ☐ Physical Exam

☐ Spina Bifida
☐ Anencephaly
☐ Encephalocele
☐ Cleft Palate
☐ Cleft Lip
☐ Cleft Lip/Palate
☐ Trisomy 21
☐ Gastroschisis
☐ Omphalocele
☐ Coarctation of Aorta
☐ Double Outlet Right Ventricle
☐ Hypoplastic Left Heart
☐ Interrupted Aortic Arch
☐ Pulmonary Atresia with Intact Ventricular Septum
☐ Single Ventricle
☐ Tetralogy of Fallot
☐ Transposition of the Great Vessels
☐ Tricuspid Atresia
☐ Truncus Arteriosis
☐ Unknown/Suspected Cardiac

Mother's Information

Name: _____ _____ ____ DOB: ____/____/____ MR# _____
Last First M.I.

Address: _____ Adoptive/Foster Parent(s) Name: _____
_____ Address: _____
Phone #: _____ Phone #: _____

Referrals Made:

☐ Children With Special Health Needs Program Date: ____/____/____ ☐ Other:_____ Date: ___/___/___
☐ Child Development Services Date: ____/____/____ _____ Date: ___/___/___
☐ Genetic Counseling Date: ____/____/____ _____ Date: ___/___/___

Provider Information:

Primary Pediatric Provider: _____ Phone:_____

Specialty Provider: _____ Phone:_____

Reporting Source: _____ Phone:_____

Telephone or fax completed form to:

Department of Health and Human Services
Maine Birth Defects Program
11 SHS, 7th Floor, 286 Water Street
Augusta, ME 04333-0011
Fax: (207) 287-5355

☐ **Check if more forms needed**

Yellow – Hospital/Provider copy

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May 2007